Clear The Form

DD-013-1-PF (6-06)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

UTILIZATION REVIEW (UR) NURSING WORKSHEET
HEALTH CARE SERVICES

CLIENT'S NAME *(Last, First, M.I.)*	BIRTHDATE	I.D. NO.

CAREGIVER'S/GUARDIAN'S NAME	PHONE NO.
DISTRICT NURSE'S NAME	PHONE NO.
SUPPORT COORDINATOR'S NAME	PHONE NO.

ADMIT FROM *(Home, Doctors Office, ER, etc.)*	ADMIT TO *(Facilities Name)*	HEALTH PLAN
DATE ADMITTED	DATE DISCHARGED	LENGTH OF STAY

DIAGNOSIS/PROBLEM(S)

FACILITY DISCHARGE COORDINATOR'S NAME	PHONE NO.
FACILITY SOCIAL WORKER'S NAME	PHONE NO.
HEALTH PLAN UR NURSE'S NAME	PHONE NO.
ATTENDING PHYSICIAN'S NAME	PHONE NO.

ANTICIPATED DISCHARGE DATE	ACTUAL DISCHARGE DATE	TYPE OF CARE ☐ Home ☐ FP ☐ ICF/MR ☐ Group Home ☐ NF ☐ Other:

PHYSICIAN'S D/C ORDERS *(Must be verified on all foster placements)*	DATE

DISCHARGE NOTIFICATION TO WHOM AND DATE

SUPPORT COORDINATOR'S NOTIFICATION TO DPM *(Placement, ICF/MR, FP, NF)*	DATE
HEALTH CARE SERVICES REPRESENTATIVE'S NAME	DATE
DPM'S NAME *(Notify about all placement changes: ICF/MR, FP, NF)*	DATE
MEDICAL DIRECTOR'S NAME *(Notification by Health Care Services if ICF/MR level of care changes)*	DATE
DES/DDD ASSISTANT DIRECTOR'S SIGNATURE *(Required for placement in ICF/MR or NF)*	DATE

ADDITIONAL NEEDS

EQUIPMENT/SUPPLIES

TRANSPORTATION	FAMILY EDUCATION/TRAINING

HOME NURSING NEEDS

MEDICATIONS	OTHER

QA ISSUES IDENTIFIED	UIR SENT ☐ Yes ☐ No
COMPLETED BY	DATE

CONCURRENT REVIEW

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SUBSEQUENT REVIEWS AND DATES

Routing: **Original** – Nurse, **Copy** – Support Coordinator, **Copy** – MCO